EXHIBIT A

CHAPTER 3

PRESCRIPTION DRUG PRICES

One of the charges of this study was to examine the differences in drug prices paid by people with and without prescription drug coverage. Prices and price differentials are important measures for understanding the market for pharmaceuticals in the United States. Analyses of pharmaceutical pricing, however, are complicated by the intricacies of this market: the process by which drug prices are determined is highly complex, involving numerous interactions and arrangements among manufacturers, wholesalers, retailers, insurers, pharmacy benefit managers (PBMs), and consumers.

In order to explain the complexity of the market for pharmaceuticals, this chapter begins with a description of the distribution channels for prescription drugs and how prices are established for different purchasers. The chapter then explores the question of whether prices paid for drugs at the point of purchase differ between cash customers and insurers, using data from the Medical Expenditure Panel Survey (MEPS) and from a widely used private sector data source, IMS Health.

A key limitation on the analysis of prescription drug prices in this study is our inability to incorporate the effect of rebates provided by manufacturers to insurers or PBMs. In many instances, a manufacturer will provide a cash rebate to an insurer or PBM if the manufacturer's drugs are used by the insurer's or PBM's enrollee. Unfortunately, information about the relative size, prevalence and characteristics of these rebate arrangements is quite limited – these are confidential, private arrangements negotiated between manufacturers and insurers or PBMs. Information from industry sources and the available literature indicate that rebate amounts vary considerably by type of arrangement and by drug. They are quite considerable in some instances and relatively modest in others. Because these rebates primarily affect the ultimate price paid for prescriptions of insured individuals, failure to account accurately for the value of such rebates tends to understate the price differences facing uninsured and insured individuals.

Although we were unable to obtain information on rebates, we were able to obtain specific data from two sources, MEPS and IMS Health, that enable us to examine differences in the prices paid by consumers at the retail pharmacy point of sale. These data compare the amount paid to the pharmacy by uninsured customers to the reimbursement received by the pharmacy for insured customers (i.e., reimbursement from an insurer or PBM plus the customer's cost sharing). Given the greater market leverage of third-party payers relative to individual consumers, it might be expected

that uninsured customers will pay more than insurers for the same drugs at the retail pharmacy level. Our results from both MEPS and IMS Health support this hypothesis.

Key findings include:

- At the retail pharmacy level:

  Individuals without drug coverage pay a higher price at the retail pharmacy than the total price paid on behalf of those with drug coverage (based on analysis of MEPS data that do not include rebates but look across all drug purchases holding drug type, form, strength, and quantity constant). The differences generally held up when examining the Medicare and non-Medicare populations.

  Cash customers (including those without coverage and those with indemnity coverage) pay more for a given drug than those with third-party payments at the point of sale (based on IMS Health data for over 90 percent of the most commonly prescribed drugs). In 1999, excluding the effect of rebates, the typical cash customer paid nearly 15 percent more than the customer with third-party coverage. For a quarter of the most common drugs, the price difference between cash and third parties was even higher – over 20 percent. For the most commonly prescribed drugs, the price difference between cash customers and those with third-party coverage grew substantially larger between 1996 and 1999.

  The pattern of differences in the price paid by cash customers and those with third-party payments is different for generic and brand name drugs (based on both MEPS and IMS Health data). Percentage differences in the price paid are often smaller for brand name drugs, but absolute differences may be larger because average prices for brand name drugs are considerably higher.

- Data on manufacturer rebates, if available, would reduce the total amount paid by the insurer or PBM on behalf of insured customers, increasing the difference in the total net price. Data on rebate arrangements, however, are confidential and unavailable to this study. In some instances, the amount of the rebate may be significantly more than the price differences observed at the retail pharmacy level. In other cases, the rebates may add only modestly to the observed differences.

- Various sources produce estimates of rebates ranging from 2 percent to 35 percent of drug sales prices. These rebates are not reflected in retail prices, but are instead paid directly to insurers and other organizations that manage drug benefits after they have already reimbursed the pharmacy.

DISTRIBUTION AND PRICING OF PRESCRIPTION DRUGS

Most noninstitutionalized people, regardless of their coverage status, obtain prescription drugs through some form of retail pharmacy, including independent pharmacies, chains, pharmacies in supermarkets or mass merchandisers, and mail-order pharmacies. In 1998, sales through retail outlets accounted for 90 percent of total outpatient prescription drug sales (excluding sales to hospitals and long-term care facilities or agencies).[1]

The following description of this system will begin with the simplest series of transactions, those that culminate in a retail purchase by a consumer who pays for a prescription in full at the point of sale. Some of these customers, referred to as cash customers in this chapter, may file a claim with their insurer for reimbursement after the transaction. This description will be followed by a summary of how prices are established for private insurers and PBMs, along with a review of the special pricing systems for Medicaid, the VA, and certain other favored purchasers.

The prices paid by these various types of customers are illustrated in Table 3-1, which portrays illustrative pricing for brand name drugs. The prices in the table are based on a composite of commonly prescribed brand name drugs and reflect documented relationships among the prices for different transactions.[2] Ranges of prices are included where more precise information, particularly on drug rebates, cannot be documented. Actual price relationships vary substantially by drug, and are quite different for generic drugs. Generic drugs, for example, have much lower prices on average and the fixed costs for the pharmacy of dispensing the prescription represent a much higher proportion of the final retail price. Furthermore, approaches to pricing generic drugs in the industry are different.

[1] National Association of Chain Drug Stores, *The Chain Pharmacy: Industry Profile*, Alexandria, VA, 1999.

[2] In general most of the relationships in this table have been established with at least two different sources of data.

Table 3-1. Illustrative Example of Pricing for Brand Name Prescription Drugs

	Cash Customers (No 3rd Party Payment at Point of Sale)	Insurers and PBMs	HMO **	Medicaid	Federal Supply Schedule
List price (AWP)	$50				
Manufacturer's price (manufacturer to wholesaler or other entity)	$40 (AWP-20%)	$40* (AWP-20%)	$34 (AWP-33%)	$40*	$24 (AWP-52%)
Acquisition price (wholesaler to pharmacy)	$41	$41	n/a	$41	n/a
Retail price at pharmacy (total of amounts paid by customer and reimbursed by 3rd party payer)	$52 (AWP+ 4%)	$46* (AWP-13% +$2.50)		$41 +$2.50	
Retail price, less typical manufacturer rebate	n/a	$30 to $44 (5% to 35% rebate)		$30 to $37 (15.1% to 30% rebate)	
Ultimate (net) amount paid by final purchaser and/or consumer	$52	$30 to $44	$34 (avg.)	$30 to $37 $34 (avg.)	$24

n / a = not applicable
* without rebate
** This column refers only to HMOs that buy directly from manufacturers.

Notes: (1) Prices are based on a composite of several commonly prescribed brand-name drugs for a typical quantity of pills. For some cells in the table, the relative relationships have been calculated based on relationships reported in *How Increased Competition from Generic Drugs Has Affected Prices and Returns in the Pharmaceutical Industry* (CBO, 1998) study and on other relationships widely reported by industry sources.
(2) These prices are used for illustrative purposes only and do not represent any type of overall average.
(3) Prices reported in this table include both amounts paid by third-party payers and amounts paid by the consumer as cost sharing.

The share of purchasers who pay in full at the time of the transaction (referred to as cash customers) has been steadily decreasing in recent years. This category includes both those with no insurance coverage for drugs and those with indemnity coverage who file claims after the retail transaction is complete. In 1990, 63 percent of retail prescriptions involved cash customers, while 37 percent involved billing by the

EXHIBIT B

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

IN RE PHARMACEUTICAL INDUSTRY : MDL No. 1456

AVERAGE WHOLESALE PRICE LITIGATION, : Civil Action

--- Number

THIS DOCUMENT RELATES TO ALL CLASS : 01CV12257-PBS

ACTIONS :

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* * *

VIDEOTAPED DEPOSITION OF

STEPHEN W. SCHONDELMEYER

TAKEN ON THURSDAY, OCTOBER 14, 2004

MINNEAPOLIS, MINNESOTA

* * *

reflect on this chart long-term care purchasing at thirty-five percent off of AWP?

A. I'm not quite sure what you're asking. I believe that the estimate of the price being paid by the long-term care class of trade, which means closed door pharmacies serving patients in nursing homes for which an individual consumer can't walk up to that pharmacy, it's estimated that their prices were about thirty-five percent below AWP.

Q. And for hospitals, forty percent, correct?

A. That's the estimate. Now that includes both brands and generics as to all of these numbers which could be quite different, so that has to be taken into account.

Q. Do you recall what the differences were as between generics and branded drugs in 1991?

A. I don't recall. Again, being thirteen to fourteen years ago, I don't recall specifically, but I know that in general generics are, have been and were substantially more discounted and rebated than brand name products.

Q. Could you turn to page thirty of the

C E R T I F I C A T I O N

I hereby certify that the proceedings and evidence noted are contained fully and accurately in the notes taken by me in the deposition of the above matter, and that this is a correct transcript of the same.

Rebecca L. Klanderud

Certified Shorthand Reporter

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